MEMO

TO: Senator Nass, Co-chair, Joint Committee for the Review of Administrative Rules
Rep. Ballweg, Co-chair, Joint Committee for the Review of Administrative Rules
Fellow members, Joint Committee for the Review of Administrative Rules
FROM: Wisconsin Health Care Leadership
DATE: May 1, 2020
RE: Support for Clearinghouse Rule 19-079 (DHS 144)

We strongly support the Wisconsin Department of Health Services' (DHS) proposed updates to the student immunization regulations in Clearinghouse Rule 19-079 (DHS 144). These updates are necessary to bring Wisconsin regulations into alignment with current recommendations put forward by the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and current evidence-based best practices. Further, the proposed changes streamline existing regulations and reporting requirements between state entities and include necessary clerical updates.

In sharing our support for the proposed rule, we feel it is important to address and clarify some of the issues raised during the March 3, 2020 hearing held by the Assembly Committee on Constitution and Ethics. We appreciate your willingness to consider the following.

1. Personal, medical and religious exemptions
Wisconsin allows parents and guardians to opt-out of vaccines for children for medical, religious or personal reasons. The proposed update to DHS 144 makes no reference to rolling back the exemptions allowed under Wisconsin law.

2. Addition of the MCV4 vaccine and booster for Meningitis
MCV4 has been a recommended vaccine since 2005, with millions of doses safely administered in the United States. Wisconsin is trailing the majority of states who have added the vaccine to their immunization guidelines. In fact, 34 states require the MCV4 vaccine as part of their immunization laws; 20 of those have had rules in place for more than five years. It is this widespread endorsement and administration of MCV4 that explains the low number of cases of meningitis nationwide.

3. Autoimmune disorders and MCV4
The only autoimmune disorder that has been demonstrated to be related to vaccines in the past is Gullian Barre Syndrome (GBS), which causes transient weakness or paralysis and was associated with the "swine flu" vaccine of the mid1970s. When MCV4 first was introduced, there was initial worry that it may be associated with an increased risk of GBS. However, post-market release surveillance conducted by the CDC demonstrated that there is no increased risk of GBS following vaccination with MCV4.

4. Vaccine Adverse Events Reporting System (VAERS) data
Anyone (parent, guardian, health care provider, others) may report adverse events or reactions to VAERS. Any outcome may be reported, as long as it occurred within 30 days of the vaccination. The CDC then reviews each case and makes a determination about a potential causality. Importantly, VAERS data can be incomplete, inaccurate, unverifiable or coincidental. While VAERS is one vaccine safety resource and tool, VAERS data does not automatically indicate causation or connection to reactions following a vaccine. Statistically, a trend should be apparent if there is any possible causal relationship between the vaccine and the events reported.

5. Physician diagnosis of varicella, or immunity, and exclusion from school
The proposed rule states that a health care provider must report a "history of varicella disease," this requirement allows for either a provider diagnosis or a provider interpretation of other proof of history. Any physician would accept a positive antibody titer for varicella as proof of immunity; the argument that a titer is not allowed by the proposed rule is not correct. Clinicians would not recommend that a child come to a physician's office to be evaluated if it was suspected (s)he was actively infected. Observation by telemedicine, or a simple blood test after the child recovers, would suffice as proof.

6. Protecting children with compromised immune systems
Children who do not receive immunizations when they are eligible to do so put kids who can't be vaccinated because of medical issues, including autoimmune diseases and cancer, at great risk. For example, before the varicella vaccine was available, approximately 100 children died of chicken pox complications in the U.S. each year, and thousands had more severe complications including encephalitis (including cerebellar ataxia), pneumonia and skin infection. It is very likely that the death rate for varicella today would far exceed 100 cases per year if we did not have a vaccine. The dramatic rise in the number of antibiotic-resistant skin bacterial infections caused by methicillin resistant Staphylococcus aureus (MRSA) is a contributing factor. A child with a compromised immune system is more likely to die from varicella because many deaths are related to skin infection.

7. Definition of "Substantial outbreak"
This is an important and necessary public health tool to stop the disease from spreading to others.

In the instance of an outbreak, exclusion of an unvaccinated child – regardless of the reason for not vaccinating – from school or daycare in an outbreak protects that child from contracting the disease. This determination made in the best interest of children's health is meant to limit the chances of coming into contact with a contagious fellow classmate, as well as prohibiting the spread of the disease.

8. Tdap schedule change
The rule proposes to move the current recommendation from 6th grade to 7th grade. This change facilitates better alignment with school immunization requirements and the recommended vaccine schedule; many younger 6th graders (10 years old) don't receive the vaccine owing to the recommended schedule guidelines. As such, they become non-compliant with the school requirements and start to receive calls and letters reminding them to see their providers. The Tdap could be administered at the same visit as the meningococcal dose which streamlines the process for students, parents, providers and schools.

9. Herd Immunity
Herd immunity is central to the efficacy of immunizations. Neither natural infection nor immunization provide 100% antibody conversion in everyone. It is the combination of the vaccine plus herd immunity that provides community protection from disease. The more unvaccinated people in any particular population, the greater the risk to both the unvaccinated people and those who may still be susceptible despite vaccination.

10. Vaccines administered
The required vaccinations provide protection against 16 vaccine-preventable diseases, including diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, chicken pox, pneumococcal disease, hepatitis A, hepatitis B, meningococcal disease, HPV, rotavirus, Hib, and flu. These all represent serious illnesses with potential severe and permanent consequences.

11. Financial implications
Physicians are not immunizing for financial gain. Physicians continue to administer vaccines because science has demonstrated vaccines are important to the safety and well-being of their patients and the community at-large. The current pandemic clearly illustrates the scientific efficacy of vaccines.

Thank you for your consideration. Please contact any of the following contacts with questions or concerns.

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Supporting organizations:

- Advocate Aurora Health
- Children's Health Alliance of Wisconsin
- Children's Wisconsin
- Kids Forward
- Marshfield Clinic Health System
- Marshfield Children's Hospital
- Mayo Clinic Health System
- Medical College of Wisconsin
- Rural Wisconsin Health Cooperative
- Sixteenth Street Community Health Center
- Southern Wisconsin Immunization Coalition
- UW Health
- UW Health/AFCH
- University of Wisconsin School of Medicine and Public Health
- Wisconsin Academy of Family Physicians
- Wisconsin Association of School Nurses
- Wisconsin Chapter of the American Academy of Pediatrics
- Wisconsin Medical Society
- Wisconsin Primary Health Care Association